SEASONAL

2009-2010 Vaccine Administration Record

Information about the person to receive vaccine (please print): *Required Fields

Name: (Last, First, MI)*	AGE:	DOB: (MM/DD/YY)*	Sex: (Circle)* M F
Address:*			
City:*	State:*	Zip:*	Phone:* ( )

INSURANCE INFORMATION: *Include the prefix and suffix with the insurance ID number, if applicable.*

Insurance Company:*	Member ID #:*	Group ID #:

If Patient is not the Subscriber, please complete the following:

Subscriber's Name: (Last, First, MI)*		Subscriber's DOB:	Sex: (Circle)* M F
Subscriber's Address:* (If different from address above)			
City:*	State:*	Zip: *	Phone:* ( )
Patient Relationship to Subscriber:* (Circle)	Spouse	Child	Other

OTHER INSURANCE INFORMATION: *Include the prefix and suffix with the insurance ID number, if applicable.*

Insurance Company:*	Member ID #:*	Group ID #:

I give permission for my insurance company to be billed.

X_____ Date: _____

(Signature of patient, parent or legal guardian)

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For Clinic/Office Use: Contact Person: Christine Connolly Phone Number: 781-316-3170

Vaccine Name:* (Circle)	Vaccine Manufacturer:	Vaccine Lot Number:	Date Vaccine Administered:*	Vaccine Type:* (Circle)	Injection Site: * (Circle)	Injection Route:* (Circle)
Seasonal Influenza			12/30/09	Dose #1 Dose #2	Right Arm Left Arm Right Leg Left Leg	Intramuscular Intranasal

Clinic Site Name: Arlington Health Department Site PIN# : 11828

Clinic Address: 27 Maple St. Arlington MA Vaccine Administrator: ***_____

Date Vaccine Information Statement (VIS) given: 12/30/09 Date on VIS: 10/2/09

Signature of Vaccine Administrator: ***_____ Date: 12/30/09

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